Children's Hospital of Wisconsin

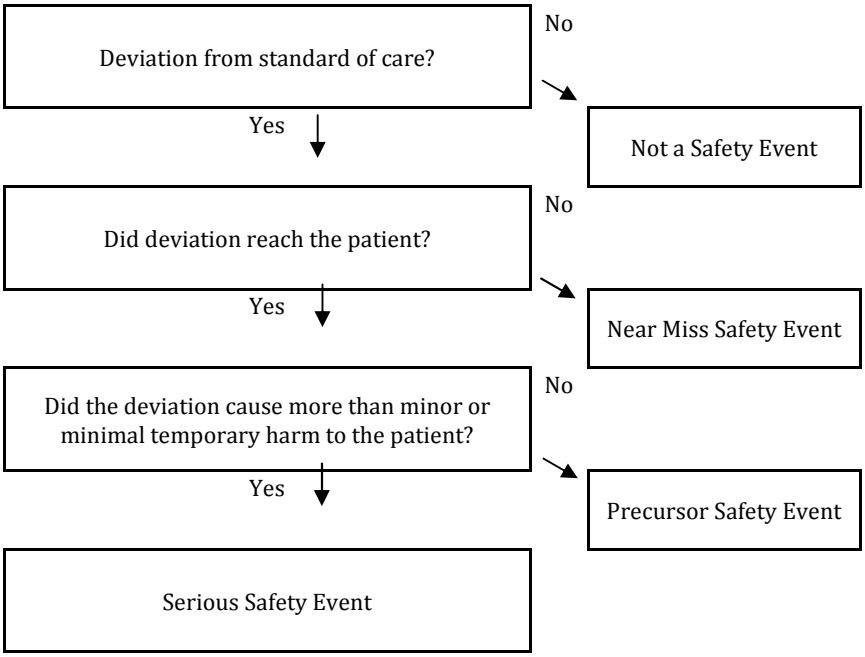
Solutions for Patient Safety: Can CHWCS apply methods developed to improve the safety of inpatient medical care to our community services programs?

Solutions for Patient Safety (SPS) is a collaboration among 70 Children's' Hospitals to improve safety that began in 2009 with 7 children's hospitals in Ohio. Children's Hospital of Wisconsin joined the collaborative in 2013 and is looking beyond inpatient medical service to implement the concepts system-wide with special attention on our Family Case Management and Intensive In-home programs.

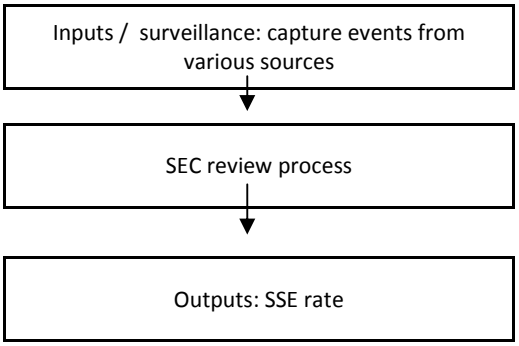
SPS Key Goals

- A key component of improving patient safety is to promote *a culture of safety*
- Partner hospitals will develop sustainable, scientifically-based approaches to reduce health care-associated infections and medication errors
- Participating institutions will share information within and across institutions, and then work to replicate best practices and outcomes with providers nationwide
- The partnership will focus on improving measurement and tracking processes, which will make data collection more complete, allowing for accurate benchmarks

SPS Safety Event Classification Flowchart



System improvement is identified across multiple events which means a system needs to ensure as many safety events as possible are captured and reviewed



Creating a Culture of Safety

Surveying staff on safety and using a Just Culture framework

1. Culture of Client Safety Survey
    - How do our staff rate the safety of the service we provide
    - How willing are our staff to report safety events
    - Do staff feel they can "stop the line" when they believe a client's safety is at risk

2. Just Culture: a values-supportive system of shared accountability
    - Organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner.
    - Employees are in turn accountable for the quality of their choices and for reporting both their errors and system vulnerabilities.
    - Humans are fallible and therefore cannot be held accountable for an expectation of perfection; we must instead create expectations that are somewhat less than perfect, and design our system to compensate for human imperfection. Ultimately, there are two things we have control over, *the reliability of the systems in which we put our employees* and the behavioral choices our employees make.

Becoming a high reliability organization

Ensuring activities that address the safety of our clients occur consistently

99.9% = 1 miss in 1000

99.0% = 1 miss in 100

90.0% = 1 miss in 10